AEROPILL- F Tablets

(Montelukast sodium 10 mg+ Fexofenadine hydrochloride 120 mg)

Preface-

Allergic Rhinitis (AR) is a common disease worldwide, affecting about 10–50% of the population. It takes a toll on the patient's quality of life, cognitive and learning functions, decision-making and self-perception and, if left untreated, can contribute to co-morbidities, including asthma, sinusitis and otitis media with effusion or the development of nasal polyps.

AEROPILL F is a combination of an antileukotriene montelukast 10 mg with the second generation antihistamine fexofenadine 120 mg.

Montelukast in Aeropill- F is a selective and orally active leukotriene receptor-antagonist that inhibits $CysLT_1$ with 24-hour action. It has been shown to decrease the number of eosinophils in the blood of patients with AR, suggesting a decrease in the inflammation and improvement in daytime and night-time symptoms as well as to improve the disease-related quality of life.

Fexofenadine hydrochloride in Aeropill - F, a second-generation antihistamine, is the pharmacological metabolite of terfenadine and a potent and selective antagonist of peripheral H_1-receptors. It has an early onset of action as compared to levocetirizine, and causes a significantly higher reduction in the wheal size after 3 to 6 hours when compared to desloratadine. Fexofenadine is as effective as the popular antihistamine, cetirizine, but it lacks the sedating effects associated with cetirizine. This is because of its inability to cross the blood–brain barrier. Fexofenadine is also superior to loratadine in improving nasal congestion, ocular symptoms and the quality of life for patients with AR.

The combination of montelukast and fexofenadine has been shown to be superior to monotherapy in a randomized, double-blind, multi-centred, prospective study with 275 adult patients in terms of reduction in nasal obstruction, nasal resistance as well as in daily symptoms and also offered higher patient satisfaction.

Thus, with the introduction of AEROPILL F , there opens up another treatment option for patients with AR who want complete control along with no sedation.

Composition

AEROPILL F Tablets

Each uncoated tablet contains

Montelukast sodium IP equivalent to montelukast.....10 mg

Fexofenadine hydrochloride IP.....120 mg

Excipients ..... q.s.

Dosage Form

Oral tablet

Description

AEROPILL F Tablets are a combination of montelukast sodium and fexofenadine hydrochloride. Montelukast sodium is a selective and orally active leukotriene receptor antagonist that inhibits the cysteinyl leukotriene type-1 receptor ($CysLT_1$).

Fexofenadine hydrochloride, the pharmacologically active metabolite of terfenadine, is a potent and selective antagonist of peripheral H_1-receptors.

It has been demonstrated by recent studies that the treatment of allergic rhinitis with concomitant administration of an anti-leukotriene and an antihistamine shows significantly better symptom relief compared with the modest improvement in rhinitis symptomatology with each of the treatments alone.

Pharmacology

As AEROPILL F Tablets are a combination of montelukast and fexofenadine, the pharmacological properties of both the molecules are given separately.

Pharmacodynamics

Montelukast

The CysLTs (LTC_4, LTD_4, LTE_4) are potent inflammatory eicosanoids released from various cells, including mast cells and eosinophils. These important pro-asthmatic mediators bind to the

CysLT receptors. The $CysLT_1$ receptor is found in the human airway (including airway smooth muscle cells and airway macrophages) and on other pro-inflammatory cells (including eosinophils and certain myeloid stem cells). CysLTs have been correlated with the pathophysiology of asthma and allergic rhinitis.
In allergic rhinitis, CysLTs are released from the nasal mucosa after allergen exposure during both early- and late-phase reactions and are associated with the symptoms of allergic rhinitis. The intranasal challenge with CysLTs has been shown to increase nasal airway resistance and symptoms of nasal obstruction.

Montelukast is an orally active compound that binds with high affinity and selectivity to the $CysLT_1$ receptor. Montelukast inhibits the physiologic actions of LTD_4 at the $CysLT_1$ receptor without any agonist activity.

Fexofenadine

Fexofenadine hydrochloride is a non-sedating H_1 antihistamine. Fexofenadine is a pharmacologically active metabolite of terfenadine.
Human histamine wheal and flare studies following single and twice-daily doses of fexofenadine hydrochloride demonstrate that the drug exhibits an antihistaminic effect beginning within 1 hour, achieving maximum effect at 6 hours, and lasting for 24 hours. There was no evidence of tolerance to these effects after 28 days of dosing. A positive dose–response relationship between doses of 10 mg and 130 mg taken orally was found to exist. In this model of antihistaminic activity, it was found that doses of at least 130 mg were required to achieve a consistent effect that was maintained over a 24-hour period. Maximum inhibition in skin wheal and flare areas was greater than 80%. Clinical studies conducted in seasonal allergic rhinitis have shown that a dose of 120 mg is sufficient for 24 hour efficacy.

In seasonal allergic rhinitis patients who were given fexofenadine hydrochloride up to 240 mg twice daily for 2 weeks, no significant differences in the QT_c intervals were observed when compared to placebo. Also, no significant change in the QT_c intervals was observed in healthy subjects given fexofenadine hydrochloride up to 60 mg twice daily for 6 months, 400 mg twice daily for 6.5 days, and 240 mg once daily for 1 year, when compared to placebo.

Pharmacokinetics

Montelukast

Absorption

After administration of a 10 mg film-coated tablet to fasted adults, the mean peak montelukast plasma concentration (C_{max}) is achieved in 3 to 4 hours (T_{max}). The mean oral bioavailability is 64%. The oral bioavailability and C_{max} are not influenced by a standard meal in the morning.

Distribution

Montelukast is more than 99% bound to plasma proteins. The steady-state volume of distribution of montelukast averages 8 to 11 litres.

Metabolism

Montelukast is extensively metabolized. In studies with therapeutic doses, plasma concentrations of the metabolites of montelukast are undetectable at the steady state in adults and paediatric patients. *In vitro* studies using human liver microsomes indicate that cytochromes P450 3A4 and 2C9 are involved in the metabolism of montelukast.

Elimination

The plasma clearance of montelukast averages 45 mL/min in healthy adults. Following an oral dose of radiolabelled montelukast, 86% of the radioactivity was recovered in 5-day faecal collections and <0.2% was recovered in the urine. Coupled with estimates of montelukast oral bioavailability, this indicates that montelukast and its metabolites are excreted almost exclusively via the bile.

In several studies, the mean plasma half-life of montelukast ranged from 2.7 to 5.5 hours in healthy young adults. The pharmacokinetics of montelukast is nearly linear for oral doses up to 50 mg. During once-daily dosing with 10 mg montelukast, there is little accumulation of the parent drug in plasma (14%).

Fexofenadine

The single- and multiple-dose pharmacokinetics of fexofenadine are linear for oral doses up to 120 mg b.i.d. A dose of 240 mg b.i.d. produced a slightly greater than proportional increase (8.8%) in the steady-state area under the curve (AUC), indicating that fexofenadine pharmacokinetics are practically linear at doses between 40 mg and 240 mg taken daily.

Absorption

Fexofenadine hydrochloride is rapidly absorbed into the body following oral administration, with the T_{max} occurring at approximately 1–3 hours post-dose. The mean C_{max} value was approximately 427 ng/ml following the administration of a 120 mg dose once daily.

Distribution

Fexofenadine is 60–70% plasma protein-bound.

Biotransformation

Fexofenadine undergoes negligible metabolism (hepatic or non-hepatic) as it was the only major compound identified in the urine and faeces of animals and humans. The plasma concentration profiles of fexofenadine follow a bi-exponential decline, with a terminal elimination half-life ranging from 11 to 15 hours after multiple dosing.

Elimination

The major route of elimination is believed to be via biliary excretion, while up to 10% of the ingested dose is excreted unchanged through the urine.

Indications

AEROPILL F Tablets are indicated for the relief of symptoms of allergic rhinitis (seasonal and perennial) whenever a combination is indicated.

Dosage and Administration

Adult (> 15 Years of ageP): One tablet once daily

Contraindications

AEROPILL F Tablets are contraindicated in patients with a known hypersensitivity to montelukast, fexofenadine or to any of the excipients.

Warning and Precautions

Montelukast

Eosinophilic Conditions

Patients on therapy with montelukast may present with systemic eosinophilia, sometimes exhibiting clinical features of vasculitis consistent with Churg-Strauss syndrome, a condition that

is often treated with systemic corticosteroid therapy. These events usually, but not always, have been associated with the reduction of oral corticosteroid therapy. Physicians should be alert to eosinophilia, vasculitic rash, worsening pulmonary symptoms, cardiac complications, and/or neuropathy presenting in their patients. A causal association between montelukast and these underlying conditions has not been established.

Neuropsychiatric Events

Neuropsychiatric events have been reported in adult and paediatric patients taking montelukast. Postmarketing reports with montelukast use include agitation, aggressive behaviour or hostility, anxiousness, depression, dream abnormalities, hallucinations, insomnia, irritability, restlessness, somnambulism, suicidal thinking and behaviour (including suicide), and tremor.

Patients with known aspirin sensitivity should continue avoidance of aspirin or non-steroidal anti-inflammatory agents while taking montelukast.

Fexofenadine

As with most new medicinal products there is only limited data in the elderly and renally or hepatically impaired patients. Fexofenadine hydrochloride should be administered with care in these special groups.

Patients with a history of or ongoing cardiovascular disease should be warned that antihistamines as a drug class have been associated with the adverse events of tachycardia and palpitations.

Based on the pharmacodynamic profile and reported adverse events, it is unlikely that fexofenadine hydrochloride tablets will produce an effect on the ability to drive or use machines. In objective tests, fexofenadine has been shown to have no significant effects on the central nervous system function. This means that patients may drive or perform tasks that require concentration. However, in order to identify sensitive people who have an unusual reaction to drugs, it is advisable to check the individual response before driving or performing complicated tasks.

Drug Interactions

Montelukast

In drug interaction studies, the recommended clinical dose of montelukast did not have clinically important effects on the pharmacokinetics of the following drugs: theophylline, prednisone, prednisolone, oral contraceptives (norethindrone 1 mg/ethinylestradiol 35 mcg), terfenadine, digoxin and warfarin.

Although additional specific interaction studies were not performed, montelukast was used concomitantly with a wide range of commonly prescribed drugs in clinical studies without evidence of clinical adverse interactions. These medications included thyroid hormones, sedative hypnotics, non-steroidal anti-inflammatory agents, benzodiazepines and decongestants.

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Phenobarbital, which induces hepatic metabolism, decreased the AUC of montelukast approximately 40% following a single 10 mg dose of montelukast. No dosage adjustment for montelukast is recommended. It is reasonable to employ appropriate clinical monitoring when potent cytochrome P450 enzyme inducers, such as phenobarbital, phenytoin or rifampin, are co-administered with montelukast.

In vitro studies have shown that montelukast is a potent inhibitor of CYP 2C8. However, data from a clinical drug-drug interaction study involving montelukast and rosiglitazone (a probe substrate representative of medicinal products primarily metabolised by CYP 2C8) demonstrated that montelukast does not inhibit CYP 2C8 *in vivo.* Therefore, montelukast is not anticipated to markedly alter the metabolism of medicinal products metabolised by this enzyme (e.g., paclitaxel, rosiglitazone, and repaglinide.)

In vitro studies have shown that montelukast is a substrate of CYP 2C8, and to a less significant extent, of 2C9, and 3A4. In a clinical drug-drug interaction study involving montelukast and gemfibrozil (an inhibitor of both CYP 2C8 and 2C9) gemfibrozil increased the systemic exposure

of montelukast by 4.4-fold. No routine dosage adjustment of montelukast is required upon co-administration with gemfibrozil or other potent inhibitors of CYP 2C8, but the physician should be aware of the potential for an increase in adverse reactions.

Based on *in vitro* data, clinically important drug interactions with less potent inhibitors of CYP 2C8 (e.g., trimethoprim) are not anticipated. Co-administration of montelukast with itraconazole, a strong inhibitor of CYP 3A4, resulted in no significant increase in the systemic exposure of montelukast.

Fexofenadine

Fexofenadine does not undergo hepatic biotransformation and, therefore, will not interact with other drugs through hepatic mechanisms. Co-administration of fexofenadine hydrochloride with erythromycin or ketoconazole has been found to result in an increase by two to three times in the level of fexofenadine in plasma. The changes were not accompanied by any effects on the QT_c interval and were not associated with any increase in adverse events compared to the drugs given singly.

Animal studies have shown that the increase in plasma levels of fexofenadine, observed after the co-administration of erythromycin or ketoconazole, appears to be due to an increase in gastrointestinal absorption and a decrease in either the biliary excretion or gastrointestinal secretion, respectively.

No interaction between fexofenadine and omeprazole was observed. However, the administration of an antacid containing aluminium and magnesium hydroxide gels, 15 minutes prior to fexofenadine hydrochloride, caused a reduction in the bioavailability, most likely due to binding in the gastrointestinal tract. It is advisable to leave a 2-hour gap between the administration of fexofenadine hydrochloride and aluminium- and magnesium hydroxide-containing antacids.

Fruit juices such as grapefruit, orange and apple may reduce the bioavailability and exposure of fexofenadine. Based on the population pharmacokinetics analysis of the combined data from grapefruit and orange juices studies with the data from a bioequivalence study, the bioavailability of fexofenadine was reduced by 36%. Therefore, to maximize the effects of fexofenadine, it is recommended that fexofenadine should be taken with water.

Renal Impairment

As with most new drugs, there is only limited data in renally impaired patients. Fexofenadine hydrochloride should be administered with care in these special groups.

Hepatic Impairment

As with most new drugs, there is only limited data in hepatically impaired patients. Fexofenadine hydrochloride should be administered with care in these special groups.

Pregnancy

There are no adequate and well-controlled studies of either montelukast or fexofenadine in pregnant women. Limited animal studies do not indicate the direct or indirect harmful outcomes with respect to the effects on pregnancy, embryonal/foetal development, parturition, or postnatal development. Because animal reproduction studies are not always predictive of human response, AEROPILL F Tablets should be used during pregnancy only if it is considered to be clearly essential.

Lactation

It is not known if montelukast is excreted in human milk. There are no data on the content of human milk after administering fexofenadine hydrochloride. However, when terfenadine was administered to nursing mothers, fexofenadine was found to cross into human breast milk. Therefore, AEROPILL F Tablets are not recommended for nursing mothers.

Pediatric Use

The safety and effectiveness of montelukast and fexofenadine in paediatric patients below the age of 6 months have not been established.

Geriatric

There is no data on the geriatric use of this combination. However, the following data is available on the individual components

Montelukast

No overall differences in safety or effectiveness were observed between the elderly subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but the greater sensitivity of some older individuals cannot be ruled out. The pharmacokinetic profile and the oral bioavailability of a single 10-mg oral dose of montelukast are similar in elderly and younger adults. The plasma half-life of montelukast is slightly longer in the elderly.

Fexofenadine

In subjects aged 65 years and above, the reported clinical experience has not identified differences in responses between the geriatric and younger subjects. This drug is substantially excreted by the kidneys and, hence, the risk of toxic reactions to this drug may be greater in patients with impaired renal function. Because elderly patients are more likely to have decreased renal function, care should be taken in dose selection, and it may be useful to monitor renal function.

Undesirable Effects

There is no data available on undesirable effects of this combination. However, side effects have been reported with individual molecules.

Montelukast

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in clinical practice.

The most common adverse reactions (incidence >/= 5% and greater than placebo; listed in descending order of frequency) in controlled clinical trials were: upper respiratory infection, fever, headache, pharyngitis, cough, abdominal pain, diarrhea, otitis media, influenza, rhinorrhea, sinusitis, otitis.

Montelukast has been evaluated for safety in approximately 2950 adult and adolescent patients with asthma 15 years of age and older in clinical trials. In placebo-controlled clinical trials, the following adverse experiences reported with montelukast occurred in greater than or equal to 1% of patients and at an incidence greater than that in patients treated with placebo: abdominal pain, asthenia/fatigue, fever, trauma, dyspepsia, dental pain, infectious gastroenteritis,

headache, dizziness, influenza, cough, nasal congestion, rash, increased ALT and AST and pyuria.

Cumulatively, 569 patients were treated with montelukast for at least 6 months, 480 for one year, and 49 for two years in clinical trials. With prolonged treatment, the adverse experience profile did not significantly change.

Montelukast has been evaluated for safety in 2199 adult and adolescent patients with seasonal allergic rhinitis 15 years of age and older in clinical trials. Montelukast administered once daily in the morning or in the evening had a safety profile similar to that of placebo. In placebo-controlled clinical trials, the following event was reported with montelukast with a frequency >/= 1% and at an incidence greater than placebo: upper respiratory infection, 1.9% of patients receiving montelukast vs. 1.5% of patients receiving placebo. In a 4-week, placebo-controlled clinical study, the safety profile was consistent with that observed in 2-week studies. The incidence of somnolence was similar to that of placebo in all studies.

Montelukast has been evaluated for safety in 3357 adult and adolescent patients 15 years of age and older with perennial allergic rhinitis of whom 1632 received montelukast in two, 6-week, clinical studies. Montelukast administered once daily had a safety profile consistent with that observed in patients with seasonal allergic rhinitis and similar to that of placebo. In these two studies, the following events were reported with montelukast with a frequency >/= 1% and at an incidence greater than placebo: sinusitis, upper respiratory infection, sinus headache, cough, epistaxis, and increased ALT. The incidence of somnolence was similar to that of placebo.

Montelukast has been evaluated for safety in 476 pediatric patients with asthma 6 to 14 years of age. Cumulatively, 289 pediatric patients were treated with montelukast for at least 6 months, and 241 for one year or longer in clinical trials. The safety profile of montelukast in the 8-week, double-blind, pediatric efficacy trial was generally similar to the adult safety profile. In pediatric patients 6 to 14 years of age receiving montelukast, the following events occurred with a frequency >/= 2% and more frequently than in pediatric patients who received placebo: pharyngitis, influenza, fever, sinusitis, nausea, diarrhea, dyspepsia, otitis, viral infection, and laryngitis. The other adverse effect reported frequently in clinical trials with montelukast in this age group was headache. The frequency of less common adverse events was comparable between montelukast and placebo. With prolonged treatment, the adverse experience profile did not significantly change.

In studies evaluating growth rate, the safety profile in these pediatric patients was consistent with the safety profile previously described for montelukast. In a 56-week, double-blind study evaluating growth rate in pediatric patients 6 to 8 years of age receiving montelukast, the following events not previously observed with the use of montelukast in this age group occurred with a frequency >/= 2% and more frequently than in pediatric patients who received placebo: headache, rhinitis (infective), varicella, gastroenteritis, atopic dermatitis, acute bronchitis, tooth infection, skin infection, and myopia.

Montelukast has been evaluated for safety in 573 pediatric patients 2 to 5 years of age in single- and multiple-dose studies. Cumulatively, 426 pediatric patients 2 to 5 years of age were treated with montelukast for at least 3 months, 230 for 6 months or longer, and 63 patients for one year or longer in clinical trials. In pediatric patients 2 to 5 years of age receiving montelukast, the following events occurred with a frequency >/= 2% and more frequently than in pediatric patients who received placebo: fever, cough, abdominal pain, diarrhea, headache, rhinorrhea, sinusitis, otitis, influenza, rash, ear pain, gastroenteritis, eczema, urticaria, varicella, pneumonia, dermatitis, and conjunctivitis. Another adverse effect commonly reported in the clinical trials with montelukast in this age-group was thirst.

Montelukast has been evaluated in 280 pediatric patients with seasonal allergic rhinitis 2 to 14 years of age in a 2-week, multicenter, double-blind, placebo-controlled, parallel-group safety study. Montelukast administered once daily in the evening had a safety profile similar to that of placebo. In this study, the following events occurred with a frequency >/= 2% and at an incidence greater than placebo: headache, otitis media, pharyngitis, and upper respiratory infection.

The safety in patients 2 to 14 years of age with perennial allergic rhinitis is supported by the safety in patients 2 to 14 years of age with seasonal allergic rhinitis. The safety in patients 6 to 23 months of age is supported by data from pharmacokinetic and safety and efficacy studies in asthma in this pediatric population and from adult pharmacokinetic studies.

Montelukast has been evaluated for safety in 175 pediatric patients 6 to 23 months of age with asthma. The safety profile of montelukast in a 6-week, double-blind, placebo-controlled clinical study was generally similar to the safety profile in adults and pediatric patients 2 to 14 years of age. In pediatric patients 6 to 23 months of age receiving montelukast, the following events occurred with a frequency >/= 2% and more frequently than in pediatric patients who received

placebo: upper respiratory infection, wheezing; otitis media; pharyngitis, tonsillitis, cough; and rhinitis. The frequency of less common adverse events was comparable between montelukast and placebo. The other commonly reported adverse effects in clinical trials of montelukast in this age group included hyperkinesia, asthma, diarrhoea, eczematous dermatitis, rash.

Safety and effectiveness in pediatric patients younger than 12 months of age with asthma have not been established.

The following adverse reactions have been reported in post-marketing use

Blood and lymphatic system disorders: Increased bleeding tendency, thrombocytopenia.
Immune system disorders: Hypersensitivity reactions including anaphylaxis, hepatic eosinophilic infiltration.
Psychiatric disorders: Agitation including aggressive behavior or hostility, anxiousness, depression, disorientation, psychomotor hyperactivity dream abnormalities including nighmares, hallucinations, insomnia, irritability, memory impairment, restlessness, somnambulism, suicidal thinking and behavior (including suicide), tremor, disturbance in attention.
Nervous system disorders: Drowsiness dizziness, paraesthesia/hypoesthesia, seizures.
Respiratory, thoracic and mediastinal disorders: Epistaxis, Churg-Strauss Syndrome, pulmonary eosinophilia
Cardiac disorders: Palpitations.
Gastro-intestinal disorders: Diarrhoea, dry mouth, dyspepsia, nausea, vomiting, pancreatitis.
Hepatobiliary disorders: Elevated levels of serum transaminases (ALT, AST), rare cases of cholestatic hepatitis, hepatocellular liver-injury, and mixed-pattern liver injury have been reported in patients treated with montelukast. Most of these occurred in combination with other confounding factors, such as use of other medications, or when montelukast was administered to patients who had underlying potential for liver disease, such as alcohol use or other forms of hepatitis.
Skin and subcutaneous tissue disorders: Angiooedema, bruising, urticaria, pruritus, rash, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome/toxic epidermal necrolysis.
Musculoskeletal and connective tissue disorders: Pyrexia, Arthralgia, myalgia including muscle cramps
General disorders and administration site conditions: Asthenia/fatigue, malaise, oedema.

Effects on ability to drive and use machines: Montelukast is not expected to affect a patient's ability to drive a car or operate machinery. However, in very rare cases, individuals have reported drowsiness or dizziness.
Patients with asthma on therapy with montelukast may present with systemic eosinophilia, sometimes presenting with clinical features of vasculitis consistent with Churg-Strauss syndrome, a condition which is often treated with systemic corticosteroid therapy. These events usually, but not always, have been associated with the reduction of oral corticosteroid therapy. Physicians should be alert to eosinophilia, vasculitic rash, worsening pulmonary symptoms, cardiac complications, and/or neuropathy presenting in their patients.

Fexofenadine

In controlled clinical trials, the most commonly reported adverse events were headache (7.3%), drowsiness (2.3%), nausea (1.5%) and dizziness (1.5%). The incidence of these events observed with fexofenadine was similar to that observed with placebo. Back pain and dysmenorrhoea were also observed in clinical trials with fexofenadine.

Events that have been reported with incidences of less than 1% and similar to placebo in controlled trials, and have also been reported rarely during postmarketing surveillance include the following: Fatigue, insomnia, nervousness and sleep disorders or paroniria such as nightmares/ excessive dreaming (paroniria), as well as tachycardia, palpitations and diarrhoea. In rare cases, rash, urticaria, pruritus, and hypersensitivity reactions with manifestations such as angio-oedema, chest tightness, dyspnoea, flushing and systemic anaphylaxis have also been reported. Other reported effects included skin disorders such as rash, urticaria and pruritis.

Overdose

There is no data reported on the overdosage of this combination. However, overdosage has been reported with individual molecules.

Montelukast

No mortality occurred following single, large oral doses of montelukast in mice and rats. Montelukast has been administered at doses of up to 200 mg/day to adult patients for 22 weeks and, in short-term studies, up to 900 mg/day to patients for approximately a week without clinically important adverse experiences.

There have been reports of acute overdosage in paediatric patients in postmarketing experience and clinical studies of up to at least 150 mg/day with montelukast. The clinical and laboratory findings observed were consistent with the safety profile in adults and older paediatric patients. There were no adverse experiences reported in the majority of overdosage reports. The most frequently occurring adverse experiences were consistent with the safety profile of montelukast and included abdominal pain, somnolence, thirst, headache, vomiting and psychomotor hyperactivity. It is not known whether montelukast is removed by peritoneal dialysis or haemodialysis.

Fexofenadine

Dizziness, drowsiness, fatigue and dry mouth have been reported with overdosage of fexofenadine hydrochloride. Single doses up to 800 mg and doses up to 690 mg twice daily for 1 month, or 240 mg once daily for 1 year have been administered to healthy subjects without the development of clinically significant adverse events, as compared with placebo. The maximum tolerated dose of fexofenadine hydrochloride has not been established. Standard measures should be considered to remove any unabsorbed medicinal product. Symptomatic and supportive treatment is recommended. Haemodialysis does not effectively remove fexofenadine hydrochloride from blood.

Incompatibility

Not applicable.

Packaging Information

AEROPILL F Tablets..... Alu Alu pack of 10 tablets